STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	03/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

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F000000	This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00122963. Complaint IN00122963- Substantiated with no deficiencies. Survey dates: March 12, 13, 14, 15, and 18, 2013. Facility number: 011151 Provider number : 155794 AIM number : N/A Survey team: Michelle Hosteter, RN-TC Janet Stanton, RN Census bed type: SNF: 10 Residential: 91 Total: 101 Census payor type: Medicare : 4 Other: 6 Residential: 91 Total : 101 Residental sample : 7 These deficiencies reflect state	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality Review completed by Tammy Alley RN on March 21, 2013.			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview	F000225	**What corrective action will be**	04/17/2013

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	the facility failed to ensure verbal abuse was immediately reported for 1 of 1 allegations of verbal abuse for 1 who met the QCLI (Quality Care Life Indicator) criteria for abuse. (Resident #1) Findings: During an interview with Resident #1 on 3/11/13 at 11 A.M., he indicated that staff had yelled at him. A request was made of the Administrator for an investigation of allegation of abuse related to Resident #1 on 3/13/13 at 3:00 p.m., and was provided 3/13/13 at 3:45 p.m. In an interview with the Administrator on 3/14/13 at 3:45 p.m., she indicated the staff did not report immediately to the former Administrator or other staff. In the investigation for Resident #1 dated 1/3/13, the resident indicated he had been verbally threatened at by staff on 12/26/12. The investigation indicated the Administrator was not reported to immediately by LPN #2, who identified this concern in nursing notes on 12/26/12.		**taken by the facility?** The internal investigation completed by the Administrator did not substantiate the allegation of abuse regarding resident #1. However, the reporting of the abuse by the staff to the Administrator did not occur within the required timeframe. All staff will be educated by the Administrator regarding the Abuse Prohibition Policy and Procedure by 4-17-13. All new staff will be educated regarding the Abuse Prohibition Policy and Procedure during general orientation and annually thereafter. All allegations of abuse will be reported immediately to their supervisor and Administrator. The person suspected of abuse will be suspended immediately pending investigation. The investigation will be initiated immediately by the Administrator following the allegation. The Social Service Director will include times of resident interviews to her resident abuse questionnaire for future investigations. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Criminal background and reference checks have been competed on all staff. All staff will be re-educated on our Abuse	

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	The nursing note entry dated 12/26/12 at 8:00 p.m., indicated, "...Res (resident) stating CNA (Certified Nursing Assistant) threatened him...." The investigation completed on 1/3/13 for the allegation of verbal abuse was not complete. The emailed statement from LPN #2 did not indicate the full name of CNA #1 who reportedly threatened Resident #1. The statement from CNA #2 also did not include the name of the alleged perpetrator. The information gathered by Social Services did not include the times when she interviewed the other residents. The facility did not include evidence of suspension of CNA #1 to ensure she was not working while the allegation of verbal abuse was being investigated. 3.1-28(2)(c) 3.1-28(2)(d)		Prohibition Policy and Procedure by 4/17/13. All new hires will be educated during general orientation and then annually thereafter. All active clinical records will be audited for documentation referring to possible abuse and to ensure that the Abuse Prohibition Policy and Procedure was followed. **What measures will be put into place to ensure the practice does not recur?** The DON will review the 24 hour report and nurses notes 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The Administrator and DON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the Administrator and DON and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their abuse prohibition policy was implemented for 1 of 1 allegations of verbal abuse for 1 who met the QCLI (Quality Care Life Indicator) criteria for abuse. (Resident #1) Findings: During an interview with Resident #1 on 3/11/13 at 11 A.M., he indicated that staff had yelled at him. A request was made of the Administrator for an investigation of allegation of abuse related to Resident #1 on 3/13/13 at 3:00 p.m., and was provided 3/13/13 at 3:45 p.m. In an interview with the Administrator on 3/14/13 at 3:45 p.m., she indicated the staff did not report immediately to the former Administrator or other staff. In the investigation for Resident #1	F000226	**What corrective action will be taken by the facility?** The internal investigation completed by the Administrator did not substantiate the allegation of abuse regarding resident #1. However, the reporting of the abuse by the staff to the Administrator did not occur within the required timeframe. All staff will be educated by the Administrator regarding the Abuse Prohibition Policy and Procedure by 4-17-13. All new staff will be educated regarding the Abuse Prohibition Policy and Procedure during general orientation and annually thereafter. All allegations of abuse will be reported immediately to their supervisor and Administrator. The person suspected of abuse will be suspended immediately pending investigation. The investigation will be initiated immediately by the Administrator following the allegation. The Social Service Director will include times of resident interviews to her resident abuse questionnaire for future investigations.	04/17/2013

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	dated 1/3/13, the resident indicated he had been verbally threatened at by staff on 12/26/12. The investigation indicated the Administrator was not reported to immediately by LPN #2, who identified this concern in nursing notes on 12/26/12. The nursing note entry dated 12/26/12 at 8:00 p.m., indicated, "...Res (resident) stating CNA (Certified Nursing Assistant) threatened him...." The policy for abuse dated 11/1/12, provided by the DON on 3/15/13, indicated, "...5.1 Anyone who witnesses an incident of suspected abuse...report the incident to his/her supervisor immediately. 5.1.1 The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law...." 3.1-28(a)		**How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Criminal background and reference checks have been competed on all staff. All staff will be re-educated on our Abuse Prohibition Policy and Procedure by 4/17/13. All new hires will be educated during general orientation and then annually thereafter. All active clinical records will be audited for documentation referring to possible abuse and to ensure that the Abuse Prohibition Policy and Procedure was followed. **What measures will be put into place to ensure the practice does not recur?** The DON will review the 24 hour report and nurses notes 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?**	

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			The Administrator and DON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the Administrator and DON and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a Care Plan addressing an AICD (automatic implantable cardiac defibrillator) device and dental care for 2 of 16 records reviewed for development of careplans in a sample of 16. Resident #26 and # 27) Findings include: 1. The clinical record for Resident #26 was reviewed on 3/15/13 at 10:48 A.M. The resident was admitted to the facility on 2/25/13 with	F000279	**What corrective action will be taken by the facility?** The current care plan has been updated to reflect the AICD for resident #26. A follow-up appointment has been scheduled with the cardiologist on April 8 th , 2013. The current care plan has been updated to address the current dental concerns for resident #27. A follow-up dental appointment has been put on hold per the resident until after rehabilitation. He wishes to focus on his rehabilitation at this time. The DON will educate the nursing staff. **How will the facility identify other residents**	04/17/2013

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	diagnoses that included, but were not limited to, abdominal aortic aneurysm with surgical intervention and repair, muscle weakness, difficulty walking, atrial fibrillation, hypertension, osteoarthritis, history of spinal stenosis with history of epidural injections for pain control, and cardiomyopathy/myocardial infarction/AICD placement. The March, 2013 physician order recap (recapitulation) sheet listed orders on 2/27/13 for a daily INR (International Normalized Ratio--blood clotting laboratory test), daily weight, and vital signs (blood pressure, pulse, temperature, respirations) every shift. There were no orders for a routine (usually monthly) check of the defibrillator to be done with the resident's cardiologist or other cardiac physician specialist. One Care Plan entry, dated 3/7/13, addressed a problem of at risk for cardiac and circulatory complications related to cardiac diagnoses. One approach listed was "Monitor heart sounds for abnormal rhythm." There was no Care Plan for AICD management. In an interview on 3/15/13 at 11:20		**having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All active records have been audited and 4 residents have been identified to have internal cardiac devices. Four of the four residents that were identifed with the internal cardiac devices have been care planned accordingly. New admissions will be assessed within 24 hours of admission and all current conditions will be assessed and care planned. An interim cardiac plan of care will be initiated within 24 hours by the admitting nurse for any internal mechanical devices. An interim plan of care will be initiated within 24 hours including a dental assessment and referral if needed. **What measures will be put into place to ensure the practice does not recur?** Nursing staff will be educated on the assessment and care planning procedures for all current resident diagnoses. The DON or ADON will review all admission nursing assessments and care plans to ensure current conditions are identified. This review will take place 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up.	

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	A.M., LPN #11 indicated she did not know what an AICD was, did not know Resident #26 had one, and did not know what precautions or care were needed for a person who had an AICD device. 2. The clinical record for Resident #27 was reviewed on 3/14/13 at 1:00 p.m. Diagnoses included, but were not limited to, depression/anxiety, peripheral neuropathy, borderline diabetes, memory issues, prostate cancer and high blood pressure. The admission assessment dated 3/2/13 for Resident #27 indicated the resident did not have any oral issues and he was on regular diet. There were no notes regarding any broken teeth in the assessment. The resident's clinical record had no information regarding if Resident #27's dental services received from the facility.		**How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or ADON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON or ADON and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	There was an order on the physician's recapitulation for Amoxicillin every 4 hours as needed for dental work. The resident indicated he had broken teeth in his resident interview on 3/13/13 at 10:30 a.m. In an interview with the Social Worker on 3/14/13 at 4: 35 p.m., she indicated she was not aware the resident had any dental concerns. She indicated there was an order from the physician who saw him on the 28th and this was the first time she had seen it and did not know if there was anything going on. She indicated there was usually a form with a set of teeth in a picture in some of the charts that would indicate any problems like this. 3.1-35(a)(1)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician's orders or the Care Plan for 1 of 1 resident who experienced a large stool in the rectum that was digitally removed. (Resident #7) Findings include: The clinical record for Resident #7 was reviewed on 3/15/13 on 10:00 A.M. The resident was admitted on 10/26/12 with diagnoses that included, but were not limited to, advanced dementia with behaviors, depression, a duodenal ulcer with gastrointestinal bleeding, anemia, dysphagia (difficulty swallowing) with weight loss/poor appetite, hypertension, gastroesophageal reflux disease, Stage 3 chronic kidney disease, history of a coronary bypass surgery, and constipation. The section for "Continence" on the "Admission Nursing Evaluation" form, dated 10/26/12, indicated the resident was not continent of bowels, had constipation, and used laxatives.	F000282	**What corrective action will be taken by the facility?** Resident #7 has had no further episodes of retained soft stool in the rectum. The staff will be counseled regarding the importance of following the Bowel and Bladder protocol and physician orders for resident #7. All nursing staff will be educated on the bowel and bladder protocol and reporting the effectiveness of the treatment. MARS will be reviewed daily to ensure that staff is following physician orders. All current charts will be reviewed to ensure bowel function is being documented and treated as ordered. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All current charts will be reviewed to ensure bowel function is being documented and treated as ordered. The MARS will be reviewed for each resident to ensure that staff is following the physician orders pertaining to each resident. **What measures will be put into place to ensure**	04/17/2013

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	There was no other assessment information. The Quarterly MDS (Minimum Data Set) assessment, completed on 1/24/13, indicated the resident was severely impaired in cognitive skills for making daily decisions, was totally dependent on the physical assistance of one staff person for toileting, and was frequently incontinent of her bowels. The March, 2013 physician order recap (recapitulation) sheet included orders for: 10/26/12--Dulcolax (Bisacodyl--a stool softener) 5 mg. (milligrams) 1 tablet every morning. 10/26/12--Miralax (Polyethylene Glycol--a laxative) 17 Grams in 8 ounces of fluid daily. 10/26/12--MOM (Milk of Magnesia) 30 ml. (milliliters) daily PRN (as needed). 10/26/12--Bisacodyl 10 mg. Suppository 1 per rectum one time if MOM not effective. The November, 2012 MAR (Medication Administration Record) indicated a suppository was administered on 11/11/12 at 6:50 P.M. for "no BM in 3 days." A dose of MOM was not given on any day in November. There was no		**the practice does not recur?** Evaluation of Bowel Assessment will be completed on new admissions, current residents, significant change and quarterly thereafter. The C.N.A will document Bowel Movements Status on the ADL Tracking Grid for all residents. A Nurse Bowel Elimination Flow Sheet has been implemented to monitor bowel movements on a daily basis. The DON or ADON will audit each resident record 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or ADON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	documentation in the previous progress note dated 11/9, or the subsequent note on 11/14/12 that indicated the resident had stool elimination problems, that a suppository was given, or the results from the suppository. A physician's progress noted, dated 2/13/13, indicated "A few days ago patient found grimacing, crying--was found to have large stool in rectum--had to be digitally removed...." A Nurse's Notes progress note, dated 2/10/13 at 5:15 P.M., indicated "Resident alert. Grimacing and crying. Large stool noted in resident's rectum. After placing resident on stool/commode for awhile stool was digitally removed. Dulcolax suppository used. No results by end of shift. Passed on to night nurse...." A progress note, dated 2/11/13 at 10:00 P.M., indicated "Resident has BM [bowel movement] in rectum that was removed digitally. XLG [extra large] BM removed. Resident appeared to be relieved after stool removed. Will let day nurse know about impaction to reassess." The February, 2013 MAR indicated the resident had not received any MOM prior to the digital removal of			

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	the stool and administration of the suppository. On 3/15/13 at 11:45 A.M., the Director of Nursing provided a policy/procedure titled "Bowel Elimination Protocol." In an interview at that time, the Director of Nursing indicated that this was her written policy which she had instituted in October, 2012. The Policy/Procedure included, but was not limited to, the following information: "PROCEDURE: ... 5. Bowel movements will be recorded in the facility medical record or MAR/TAR daily by the licensed nurse... 8. Any resident not having a BM for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day. They will also be offered high fiber fruits and vegetables if not contraindicated medically... 9. Residents not having results from the laxative or stool softener will receive a suppository, if ordered by the physician. 10. If by the 4th afternoon, the resident still has had no results, the			

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	nurse will do an abdominal assessment, chart the results of the assessment and notify the MD for further orders...." The Director of Nursing indicated the facility also had a Policy/Procedure for digitally removing stool, and provided a copy on 3/15/13 at 11:45 A.M. The paper was titled "Fecal Impaction: Removal of" and was dated effective on 11/1/12. The "Policy" indicated "Digital removal of fecal impaction will be performed by a licensed nurse per physician order. This procedure is contraindicated after rectal or perineal surgery, in customers who have myocardial infarction, coronary inefficiency, pulmonary embolus, heart failure, heart block, gastrointestinal or vaginal bleeding, hemorrhoids, rectal polyps, or blood dyscrasias...." One Care Plan entry, dated 11/5/12, addressed a problem of "Constipation." The "Interventions" included, but were not limited to: "Assess and document [resident's name] for history of bowel habits include medication use, laxative use, diet, fluids, exercise, and personal remedies.			

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	Assess and document [resident's name] for usual bowel movement history, including usual pattern, time of day, amount/frequency, consistency of stool. Assess for presence of surgical intervention, diseases, and/or narcotic use that may contribute to constipation. Intervene with laxative or stool softeners as ordered...." 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to implement an effective bowel management program for 1 of 1 resident who experienced a large stool in the rectum that was digitally removed in a sample of 1. (Resident #7) Findings include: The clinical record for Resident #7 was reviewed on 3/15/13 on 10:00 A.M. The resident was admitted on 10/26/12 with diagnoses that included, but were not limited to, advanced dementia with behaviors, depression, a duodenal ulcer with gastrointestinal bleeding, anemia, dysphagia (difficulty swallowing) with weight loss/poor appetite, hypertension, gastroesophageal reflux disease, Stage 3 chronic kidney disease, history of a coronary bypass surgery, and constipation. The section for "Continence" on the "Admission Nursing Evaluation" form,	F000309	**What corrective action will be taken by the facility?** Resident #7 has had no further episodes of retained soft stool in the rectum. Staff will be educated on following the bowel and bladder protocol and reporting the effectiveness of the treatment. MARS will be reviewed daily to ensure that staff is following physician orders. All current charts will be reviewed to ensure bowel function is being documented and treated as ordered. Employees will be counseled regarding the bowel protocol. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All current charts will be reviewed to ensure bowel function is being documented and treated as	04/17/2013

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	dated 10/26/12, indicated the resident was not continent of bowels, had constipation, and used laxatives. There was no other assessment information. The Quarterly MDS (Minimum Data Set) assessment, completed on 1/24/13, indicated the resident was severely impaired in cognitive skills for making daily decisions, was totally dependent on the physical assistance of one staff person for toileting, and was frequently incontinent of her bowels. The March, 2013 physician order recap (recapitulation) sheet included orders for: 10/26/12--Dulcolax (Bisacodyl--a stool softener) 5 mg. (milligrams) 1 tablet every morning. 10/26/12--Miralax (Polyethylene Glycol--a laxative) 17 Grams in 8 ounces of fluid daily. 10/26/12--MOM (Milk of Magnesia) 30 ml. (milliliters) daily PRN (as needed). 10/26/12--Bisacodyl 10 mg. Suppository 1 per rectum one time if MOM not effective. 11/5/12--Remeron 15 mg.--1/2 tablet for appetite stimulant, mechanical soft diet. 11/2/12--Speech Therapy for swallow function and cognitive communication		ordered. The MARS will be reviewed for every resident to ensure that staff is following the physician orders pertaining to each resident. **What measures will be put into place to ensure the practice does not recur?** Evaluation of Bowel Assessment will be completed on new admissions, current residents, significant change and quarterly thereafter. The C.N.A will document Bowel Movements Status on the ADL Tracking Grid for all residents. A Nurse Bowel Elimination Flow Sheet has been implemented to monitor bowel movements on a daily basis. The DON will audit each resident record 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or ADON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be	

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	status as indicated. The November, 2012 MAR (Medication Administration Record) indicated a suppository was administered on 11/11/12 at 6:50 P.M., for "no BM in 3 days." A dose of MOM was not given on any day in November. A Nurse's progress note, dated 11/11/12, indicated "Resident is sitting in Broda chair while [family member] visits with her. Resident non-verbal, but will follow objects with eyes. No signs/symptoms of distress noted. 100% dependent for all ADLs. Resident fed snack and ate all of it, and put to bed." There was no documentation in the previous progress note dated 11/9, or the subsequent note on 11/14/12 that indicated the resident had stool elimination problems, that a suppository was given, or the results from the suppository. The November, 2012 "CNA--ADL Tracking Form" had documentation of a BM on the day shift on 11/8/12. The next BM was documented on 11/11/12 for the night shift. However, the size and consistency of each stool was not identified. A physician's progress noted, dated 2/13/13, indicated "A few days ago		brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	patient found grimacing, crying--was found to have large stool in rectum--had to be digitally removed...." A Nurse's Notes progress note, dated 2/10/13 at 5:15 P.M., indicated "Resident alert. Grimacing and crying. Large stool noted in resident's rectum. After placing resident on stool/commode for awhile stool was digitally removed. Dulcolax suppository used. No results by end of shift. Passed on to night nurse...." A progress note, dated 2/11/13 at 10:00 P.M., indicated "Resident has BM [bowel movement] in rectum that was removed digitally. XLG [extra large] BM removed. Resident appeared to be relieved after stool removed. Will let day nurse know about impaction to reassess." The February, 2013 "CNA--ADL Tracking Form" sheet had documentation the resident had one bowel movement on 2/3 during the day shift, and one bowel movement during the night shift on 2/7, 2/8, and 2/9/13. However, the size and consistency of each stool was not identified. The February, 2013 MAR indicated the resident had not received any MOM prior to the digital removal of			

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	the stool and administration of the suppository. One Care Plan entry, dated 11/5/12, addressed a problem of "Constipation." The "Interventions" were listed as: "Assess and document [resident's name] for history of bowel habits include medication use, laxative use, diet, fluids, exercise, and personal remedies; assess and document [resident's name] for usual bowel movement history, including usual pattern, time of day, amount/frequency, consistency of stool. Assess for presence of surgical intervention, diseases, and/or narcotic use that may contribute to constipation; encourage fluids to soften stool; intervene with [resident's name] on increased activity level to promote bowel function; intervene with laxatives or stool softeners as ordered; encourage [resident's name] or family to keep a diary of bowel habits as needed; instruct [resident's name] and family on pharmocologic and non-pharmocologic measures that may prevent or minimize constipation." On 3/15/13 at 11:45 A.M., the Director of Nursing provided a policy/procedure titled "Bowel			

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	Elimination Protocol." In an interview at that time, the Director of Nursing indicated that this was her written policy which she had instituted in October, 2012. The Policy/Procedure included, but was not limited to, the following information: "PROCEDURE: 1. Each resident or responsible party will be interviewed during the admission assessment about their usual bowel history, i.e. frequency of BMs, time of day, etc... 4. CNAs will report off to the charge nurse at the end of their shift if any of their residents have had a BM. 5. Bowel movements will be recorded in the facility medical record or MAR/TAR daily by the licensed nurse... 8. Any resident not having a BM for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day. They will also be offered high fiber fruits and vegetables if not contraindicated medically... 9. Residents not having results from the laxative or stool softener will receive a suppository, if ordered by the physician.			

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	10. If by the 4th afternoon, the resident still has had no results, the nurse will do an abdominal assessment, chart the results of the assessment and notify the MD for further orders.... The Director of Nursing indicated the facility also had a Policy/Procedure for digitally removing stool, and provided a copy on 3/15/13 at 11:45 A.M. The paper was titled "Fecal Impaction: Removal of" and was dated effective on 11/1/12. The "Policy" indicated "Digital removal of fecal impaction will be performed by a licensed nurse per physician order. This procedure is contraindicated after rectal or perineal surgery, in customers who have myocardial infarction, coronary inefficiency, pulmonary embolus, heart failure, heart block, gastrointestinal or vaginal bleeding, hemorrhoids, rectal polyps, or blood dyscrasias...." 3.1-37(a)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview and record review, the facility failed to identify specific target behaviors to monitor for 1 of 1 resident who was receiving antipsychotic and antidepressant medications in a sample of 10. (Resident #7) Findings include: Resident #7 was present during an interview with a family member on 3/13/13 at 1:00 P.M. The resident	F000329	**What corrective action will be taken by the facility?** Resident #7 clinical records will be reviewed with the family for history of need for the antipsychotic/antidepressant medication. These medications will be reviewed with the physician for the necessity of the medication and its continued need. Nursing staff will be educated regarding observation and documentation of signs, symptoms and side effects related to the use of these medications. **How will the**	04/17/2013

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	was observed at that time to be in a Broda chair (a specialized geri-chair). She would smile at the family member and stroke his hand. Although she would occasionally respond positively with a nod of her head for a "Yes" answer to a question, her verbal responses to the conversation were garbled and unintelligible. The clinical record for Resident #7 was reviewed on 3/15/13 on 10:00 A.M. Diagnoses included, but were not limited to, advanced dementia with behaviors, depression, a duodenal ulcer with gastrointestinal bleeding, anemia, dysphagia (difficulty swallowing) with weight loss/poor appetite, hypertension, gastroesophageal reflux disease, Stage 3 chronic kidney disease, history of a coronary bypass surgery, and constipation. The Admission MDS (Minimum Data Set) assessment, dated 11/1/12, indicated the resident had severe cognitive impairment in daily decision making, had little interest in activities, had a poor appetite, and did not have any psychosis or behaviors. A Quarterly MDS assessment, dated 1/24/13, indicated the same with no change.		**facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents receiving antipsychotic/antidepressant medication have the potential to be affected by the alleged deficient practice. All clinical records will be audited and reviewed for diagnoses and signs/symptoms to support the use of the antipsychotic/antidepressant medication. **What measures will be put into place to ensure the practice does not recur?** New diagnoses and new medications will be reviewed daily. Resident/family interviews and observation will occur within 72 hours of admission for supporting symptoms for diagnosis and use of medication. All resident records will be audited and reviewed for diagnoses and sign/symptoms to support the use of the antipsychotic/antidepressant medication. This review will be completed by the Social Service Director or DON 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not**	

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	The admission "Medication Transfer Sheet," dated 10/26/12, listed orders that included: Quetiapine (Seroquel, an antipsychotic medication) 25 mg. (milligrams), Mirtazapine (Remeron, an antidepressant medication) 15 mg. ("for weight loss," 8/19/10), and Sertraline (Zoloft, an antidepressant medication) 100 mg. Subsequent physician orders included: 10/28/12--Decrease Zoloft to 100 mg. po (by mouth) every day. 11/1/12--Add diagnosis: delusional disorder 11/5/12--Decrease Remeron 15 mg. to 7.5 mg. 12/5/12--Decrease Seroquel to 12.5 mg. po every A.M. and 25 mg. po every HS (bedtime) times 2 weeks, then D/C (discontinue) the A.M. dose and keep the HS dose. 1/24/13--Decrease Zoloft to 50 mg. po daily on 2/4/13; decrease Seroquel to 12.5 mg. every HS on 2/14/13. The December, 2012 "Behavior/Intervention Monthly Flow Record" sheet for the Sertraline medication listed a "behavior" of "Depression," with no other description. The specific manner in		**recur and what QA will be put into place?** The Social Service Director or DON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the Social Service Director and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	which the resident displayed "Depression" was not identified. The December, 2012 "Behavior/Intervention Monthly Flow Record" sheet for the Quetiapine medication had no behaviors listed, and the page was blank. The February, 2013 "Behavior/Intervention Monthly Flow Record" sheet listed medications of Zoloft, Remeron, and Seroquel. The "behaviors" listed on the sheet were "Change in mood," and "sad facials." In an interview on 3/15/13 at 2:50 P.M., the Director of Nursing indicated the Social Service Director oversaw the behavior monitoring program. After reviewing the "Behavior Flow Record" sheets, she indicated the information listed in the "Behavior" section should be more descriptive and specific in order to monitor how the resident displayed behaviors. In an interview on 3/15/13 at 3:40 P.M., the Social Service Director indicated the "Behavior/Intervention" sheets came from the facility pharmacy with the names of the medications listed at the bottom. She indicated she added the "behavior" in			

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	the box, and any diagnosis needed, if not listed. She indicated some residents do not have any symptoms of behavior. 3.1-48(a)(3)			

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STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

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F000334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure the pneumococcal vaccine was offered for 2 of 5 residents reviewed for documentation and education regarding influenza and pneumococcal vaccinations. (Resident #1 and Resident # 13) Findings include: 1. The record review for Resident #1 was completed on 3/13/13 at 2:00 p.m. Diagnoses included, but were not limited to, vascular dementia with depression, large ischemic right sided	F000334	**What corrective action will be taken by the facility?** Residents #1 and #13 received their immunizations from their private physicians within the appropriate timeframes. Documentation pertaining to the immunizations will be transcribed in their clinical record on the immunization form. All records will be audited to ensure that the influenza and pneumococcal vaccinations have been given and documented on the immunization record along with the signed consents.	04/17/2013

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	stroke, paroxysmal afib (affibrillation), right radial nephrectomy , pituitary tumor excision (9/98), chronic renal insufficiency, right bundle branch block, depression, high blood pressure, and hypercholesterolemia. The documentation for the influenza and pneumococcal vaccination were reviewed. The flu vaccination indicated no vaccination was desired. The information had no date and no signature from the resident, resident representative, or a power of attorney or healthcare designee. The pneumococcal vaccination had no signatures or dates noted and nothing marked as to whether the resident did or did not want the pneumococcal vaccination. 2. The record review for Resident #13 was completed on 3/14/13 at 9:00 a.m. Diagnoses included, but were not limited to, history of failure to thrive, dehydration, hyponatremia, lung cancer, urinary tract infection, chronic obstructive pulmonary disease, chronic back pain with history of compression fractures, depression, urinary incontinence, bilateral high frequency hearing loss, and weight loss with anorexia. The documentation for the influenza		**How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Immunization documentation pertaining to influenza and pneumococcal vaccinations will be obtained on admission and annually thereafter. Signed consents to administer the vaccinations will be obtained from the resident or responsible party. **What measures will be put into place to ensure the practice does not recur?** New admissions will be audited utilizing the new admission chart review to ensure that consents or declinations have been signed . The clinical documentation for new admissions will be audited within 72 hours of admission. All new admissions will be audited 5 days per week by the DON or ADON as part of her routine. Current resident records will be monitored quarterly with their individual care plans. The DON or ADON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be**	

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	and pneumococcal vaccination were reviewed. The pneumococcal vaccination had nothing marked as to whether the resident did or did not want the pneumococcal vaccination. There was no documentation if this was contraindicated for this resident. There was no date and no signature from the resident, resident representative, or a power of attorney or healthcare designee. In an interview with the Director of Nursing (DON) on 3/15/13 at 2:00 p.m., she indicated the informed consent for flu and pneumococcal vaccine should be signed and a notation designating whether they want the vaccination or not should be documented. A request was made of the DON for the policy for Immunizations of Pneumococcal and Influenza for residents on 3/13/13 at 11 A.M. A document titled "Immunizations: Influenza (flu) Vaccination of Residents, Staff, and Volunteers" dated 2012, was provided by DON on 3/13/13 at 1:00 p.m. The document indicated, "...If signed consent is required according to state law, it would occur at this procedural step.) D. Residents, staff and volunteers		**monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or ADON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	may refuse vaccination. Vaccination refusal and reasons why...should be documented by the facility...." There was no specific documentation in the policy regarding documentation of acceptance or refusal of the pneumococcal vaccine, or of contraindications to the vaccination. 3.1-13(a)			

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F000425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure a routine medication was available and administered to 1 of 1 resident observed during medication pass, until the medication could be obtained by the family through their own pharmacy. (Resident #13) Findings include: On 3/14/13 at 9:30 A.M., LPN #11 was observed to prepare and administer medications to Resident #13. The resident received seven pills.	F000425	**What corrective action will be taken by the facility?** The medication for resident #13 has been delivered to the facility and is being dispensed per physician order. A policy and procedure regarding the timely filling of prescriptions supplied by an outside vendor has been implemented. The MARS will be audited by nursing staff to ensure that all current ordered medications are in stock and are being dispensed per physician order. Nursing staff will be educated regarding the timely filling of prescriptions supplied by an outside vendor. **How will the facility identify other residents**	04/17/2013

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	Upon reconciliation with the physician's orders, it was determined that a Tab-A-Vite vitamin pill, scheduled to be given with the morning medications, had not been given. The order was dated 8/31/12 for Tab-A-Vite one tablet by mouth daily. The MAR (Medication Administration Record) was reviewed on 3/14/13 at 1:11 P.M.. Doses of the vitamin were circled on 3/11, 3/12, 3/13, 3/14/13, indicating the medication had not been given. The "Nurse's Medication Notes" on the reverse side of MAR sheet indicated "pharm [pharmacy] notified" on 3/11/13, and "awaiting deliver" or "awaiting arrival" on 3/13 and 3/14. Nothing was marked for 3/12/13. In an interview on 3/15/13 at 9:20 A.M., LPN #11 indicated the family "provided" the medications, meaning that the family had prescriptions filled at the pharmacy of the resident's choice and would bring in to the facility. On 3/15/13 at 2:25 P.M., a copy of the MAR sheet was provided. The Tab-A-Vite medication was not administered on 3/15/13, and the		**having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A policy and procedure regarding the timely filling of prescriptions supplied by outside vendor has been implemented along with nurse education. **What measures will be put into place to ensure the practice does not recur?** All MARS will be audited by nursing staff to ensure that all current ordered medications are in stock and are being dispensed per physician order. All resident MARS will be audited 5 days per week by the DON as part of her routine for 3 months and a pattern of compliance has been established. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or ADON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA	

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	note on the reverse side indicated "awaiting arrival." In an interview on 3/15/13 at 2:25 P.M., the Director of Nursing indicated she would have to see if she had a Policy/Procedure, but it was only common sense to get medications from the facility pharmacy until the family could provide them. In an interview on 3/18/13 at 4:45 P.M., the Director of Nursing indicated she did not have any Policy/Procedure for obtaining medications from the facility pharmacy while waiting for residents/families to receive from their own pharmacy. 3.1-25(a)		Committee meeting. The MARS will continue to be monitored weekly to ensure that all medications are available. The results are brought to the monthly QA meeting. This will continue on an ongoing basis to ensure 100% compliance is maintained.	

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F009999	STATE FINDINGS 3.1-14 PERSONNEL 1. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility and to the specific job skills. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure 4 of 4 employees reviewed, who were hired since the last annual survey on 1/4/12, had received orientation to their specific job skills. (CNA #12, #13, #15 and #16) Findings include: The records for 4 employees hired since the last annual survey on 1/4/12 were selected for review. Documentation for specific job orientation was not found for: CNA #12--hire date 8/24/12 CNA #13--hire date 9/7/12	F009999	**What corrective action will be taken by the facility?** C.N.A .# 12, C.N.A.#13, C.N.A.#15 and C.N.A.#16 will have specific job orientations and physical examinations completed by 4/17/13. C.N.A # 15, C.N.A#16, C.N.A. #13 and Server #17 will have the tuberculin skin test or if positive, the tuberculosis screen by 4/17/13. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All employee files will be audited for information pertaining to specific job orientations, PPD documentation and physical examinations. Any employee identified as lacking this information will receive the appropriate assessments and specific job orientations by 4/17/13. **What measures will be put into place to ensure the practice does not recur?** All new hires will complete the job specific job orientations during their orientation period. The tuberculin skin test documentation or if positive, the tuberculosis screen and physical examinations will be completed prior to their first day of work. The tuberculin skin test or if positive, the tuberculosis screen will be completed on an annual basis for each employee. The Business Office Manager will	04/17/2013

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	CNA #15--hire date 12/8/12 CNA #16--hire date 12/7/12 In an interview on 3/18/13 at 4:00 P.M., the Business Office Manager, who was responsible for the maintenance of the personnel files, indicated one of the forms in the file was for orientation to job skills. After reviewing the form, she indicated it was very similar to the one for general orientation, and did not address specific jobs skills required for a CNA. 2. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to obtain a physical examination, completed by Physician, Nurse Practitioner, Physician's Assistant, or Certified Nurse Specialist, for 4 of 4 employees reviewed, who were hired since the last annual survey on 1/4/12. (CNA #12, #13, #15, and #16) Findings include: The records for 4 employees hired		maintain the Employee Record checklist to ensure that all documentation is timely. The employee files will be audited on a monthly basis by the Business Office Manager. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The Business Office Manager or Administrator will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the Business Office Manager and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	since the last annual survey on 1/4/12 were selected for review. Documentation of a physical examination completed within one (1) month prior to employment was not found for: CNA #12--hired 8/24/12. A "Health Assessment" screen was completed by a facility RN on 10/2/12. CNA #13--hired 9/7/12. A "Health Assessment" screen was completed by a facility RN on 10/20/12. CNA #15--hired 12/8/12 CNA #16--hired 12/7/12 In an interview on 3/18/13 at 3:15 P.M., the Executive Director indicated that CNA #12 and CNA #13 were rotated in and out of the certified skilled unit, working at other times on the licensed Residential unit. 3. (t)(1) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding			

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	twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to obtain a first and second step tuberculin skin test for 2 of 2 employees hired since the last survey on 1/4/12; failed to obtain an annual tuberculin skin test for 1 of 1 employee, and failed to do an annual tuberculosis screen for 1 of 1 employee who had a previous positive reaction. (CNA #15, CNA #16, CNA #14, and Server #17) Findings include: The records for 4 employees hired since the last annual survey on 1/4/12 were selected for review. The records for 5 employees hired prior to the last survey were also selected for review. Documentation of tuberculin skin testing or annual tuberculosis screening was not found for: CNA #15--hired 12/8/12, no first or second step tuberculin testing prior			

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	to, or at, hire. There was no documentation of a previous negative test in the preceding 12 months. CNA #16--hired 12/7/12, no first or second step tuberculin testing prior to, or at, hire. There was no documentation of a previous negative test in the preceding 12 months. CNA #14--the employee was identified as having a previous positive tuberculin skin test. The last tuberculosis screen was dated 9/26/11. Server #17--the employee was identified as having a previous positive tuberculin skin test. No previous tuberculosis screen was found, and no current screen was found. In an interview on 3/18/13 at 4:00 P.M., the Business Office Manager, who was responsible for the maintenance of the personnel files, indicated she was unable to locate any of the tests or screens. 3.1-14(q)(7) 3.1-14(t) 3.1-14(t)(1)			

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R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure preadmission assessments were completed for 2 of 5 residents reviewed for preadmission assessments. (Resident #29 and #31) Findings include: 1. The clinical record was reviewed for Resident # 29 on 3/18/13 at 9:15 a.m. Diagnoses included, but were not limited to, high blood pressure, osteoarthritis, coronary artery disease, lung cancer and breast cancer. The clinical record had no assessments prior to Resident #29 admission date on 10/5/12 regarding residents health status.	R000214	**What corrective action will be taken by the facility?** As of November, 2012, a policy and procedure regarding pre-admission has been implemented by Senior Living Communities. Prior to admission, this assessment will be performed by a licensed nurse to determine appropriate level of care and approximate services being required. This information is based on interviews from resident and resident family members. All resident records will be reviewed for pre-admission health assessments. Prior to admission, the designee will ensure that all admission paperwork is completed and placed in the active clinical record. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The interdisciplinary team will be educated regarding the pre-admission assessment	04/17/2013

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			protocol. All resident records will be audited to determine that they are appropriate for their current level of care and for documentation pertaining to the pre-admission health status assessment. **What measures will be put into place to ensure the practice does not recur?** During the evaluation stage prior to admission, the interdisciplinary team will meet to discuss resident needs and potential level of care. The interdisciplinary team will review all pre-admission assessments and health status assessments to ascertain resident needs and determine appropriate level of care. The admission will be dependent upon the completion of the pre-admission assessment. The pre-admission assessment and health status assessment will be reviewed prior to resident admission. The ADON will audit each new admission resident record as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The ADON or designee will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any	

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	155794	A. BUILDING 00 B. WING	03/18/2013

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	2. The clinical record for Resident #31 was reviewed on 3/18/13 at 11:20 A.M. The resident was admitted on 6/18/12 with diagnoses that included, but were not limited to, history of a fractured hip, congestive heart failure, atrial fibrillation, history of rectal cancer with a distal colectomy, pulmonary nodule, depression, macular degeneration, and osteoporosis. A pre-admission evaluation of the resident's needs was not found. In an interview on 3/18/13 at 2:50 P.M., the Assistant Director of Nursing indicated she had discussed this issue with the corporate office. According to the corporate office, a system to do a pre-admission evaluation was not in place until late December, 2012. After that date, pre-admission evaluations were done in their computer system. She provided an evaluation of the resident that was completed on the date of her admission to the facility, and identified it as the "pre-admission" evaluation. She indicated she had no other evaluation of the resident prior to her admission on		recommendation made by the committee will be followed up by the ADON or designee and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	6/18/12.			

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure there was complete and thorough documentation for 3 of 7 residents reviewed for documentation. (Resident #33 and #34). Findings include: 1. The closed clinical record for Resident #33 was reviewed on 3/18/13 at 10:30 a.m. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure, low vision, and enlarged prostate. The nurses notes for 1/8/13 at 6:00 a.m., indicated, "... Res [resident] notified staff that he fell. Res states 'I was trying to turn around in the bathroom et [and] my legs gave out...family notified. MD returned call...." There was no indication of vital signs being taken anywhere in the clinical record.	R000349	**What corrective action will be taken by the facility?** Resident #33 and #34 have been discharged. The nursing staff will be educated regarding proper documentation standards for residential residents; the use of the SBAR Format for unusual occurrences; the use of the accident investigation tool; and drug disposition. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be educated regarding proper documentation standards for residential residents; the use of the SBAR Format for unusual occurrences; the use of the accident investigation tool; and drug disposition. **What measures will be put into place to ensure the practice does not recur?** The resident records will be monitored to ensure that nursing	04/17/2013

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	The nursing notes for 2/15/13 indicated, "...10 am res [resident] leaving [sign for with] to go to urgent care then to son's home...." There was explanation as to why the resident was being taken to urgent care. No prior nursing notes indicated any concerns regarding resident health status. 2. The clinical record for Resident #34 was completed on 3/18/13 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's with depression, anxiety and chronic obstructive pulmonary disease. The nurses notes for 2/12/13 at p.m., indicated, "...had drug disposition [medication-release forms] for daughter to sign [sign for with] all of the medication the facility had for res daughter refused to sign turn issue over to D.O.N...." The note did not indicate what was done with medications. In an interview with the Director of Nursing on 3/18/13 at 1:30 p.m., she indicated they did not have any documentation relating to the disposition of the drugs other than what was in the nursing notes.		documentation and adequate follow-up is completed for change of condition and drug disposition. The ADON or designee will review the records 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The ADON or designee will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the ADON or designee and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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R000354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.			
	Based on record review and interview, the facility failed to have complete documentation relating to the transfer/discharge from the facility for 2 of 2 closed records reviewed for transfer documentation. (Resident #33 and #34) Findings include: 1. The closed clinical record for Resident #33 was reviewed on 3/18/13 at 10:30 a.m. Diagnoses included, but were not limited to atrial fibrillation, congestive heart failure, low vision, and enlarged prostate. The form titled "Discharge	R000354	**What corrective action will be taken by the facility?** Resident #33 and #34 have been discharged. The nursing staff will be educated on the documentation requirements of the discharge summary and transfer form. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The nursing staff will be educated on the documentation	04/17/2013

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	Instructions for Care" dated 2/12/13 indicated the medications the resident was currently on, the name of resident, the name of the facility, that the family refused to sign, and the signature of the nurse. There was no other information pertaining to status of resident with destination, diet, or physical activity. There was no documentation of chest x-ray or tuberculin testing. 2. The closed clinical record for Resident #34 was completed on 3/18/13 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's with depression, anxiety and chronic obstructive pulmonary disease. The form titled "Discharge Instructions for Care" dated 2/15/13 indicated the medications the resident was currently on, the name of resident, the name of the facility, that the family refused to sign, and the signature of the nurse. There was no other information pertaining to status of resident with destination, diet, or physical activity. There was no documentation of chest x-ray or tuberculin testing. In an interview with the Director of		requirements of the discharge summary and transfer form. **What measures will be put into place to ensure the practice does not recur?** All pending discharges will be reviewed and monitored for appropriate transfer/discharge documentation. The ADON or designee will review the records 5 days per week as part of her routine. She will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The ADON or designee will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by the ADON or designee and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	

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	Nursing on 3/18/13 at 1:30 p.m., she indicated the discharge instructions for care form is the only place they document transfer information for the resident.			

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R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to obtain 1st and 2nd step tuberculosis skin test upon, or prior to, admission for 1 of 1 resident reviewed for admission tuberculin testing. (Resident #31 and #29) In addition, the facility failed to obtain an annual tuberculosis skin test for 1 of 5 residents reviewed for annual tuberculin testing. (Resident #30) Findings include: 1. The clinical record for Resident	R000410	**What corrective action will be taken by the facility?** Resident #29, #30 and #31 will receive the appropriate tuberculosis assessment. All resident records will be audited for compliance regarding tuberculin skin test or if positive, the tuberculosis screen. Any resident lacking sufficient documentation of series completion will have the vaccine instituted or the tuberculosis screen. This information will be recorded on the immunization record in the clinical record. **How will the facility identify other residents having the potential to be affected by the**	04/17/2013

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	#31 was reviewed on 3/18/13 at 11:20 A.M. The resident was admitted on 6/18/12. The "Immunization Record" form indicated a first step tuberculin skin test was administered on 6/18/12. The date read with the results were not recorded on the form. A second step test was recorded as administered on 7/2/12. The date read with the results were not recorded on the form. In an interview on 3/18/13 at 2:15 P.M., the Director of Nursing indicated she had checked the MAR (Medication Administration Record) and other documentation, but could not find that the tests had been read. 2. The clinical record for Resident #30 was reviewed on 3/18/13 at 10:15 A.M. An annual tuberculosis skin test, completed within the last year, was not found. In an interview on 3/18/13 at 2:15 p.m., the Director of Nursing indicated an annual test had not been done.		**same practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Any resident lacking sufficient documentation of series completion will have the vaccine instituted, along with the appropriate series documentation. **What measures will be put into place to ensure the practice does not recur?** Clinical records will be reviewed on admission and then added to the Tuberculin Testing Tracking Log Form. The ADON or designee will review the records 5 days per week as part of her routine for 3 months and a pattern of compliance is established. Once the 3 months has been completed along with the pattern of compliance, the tracking log will be reviewed on a monthly basis. The ADON or designee will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. **How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The ADON or designee will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up by	

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	3. The clinical record was reviewed for Resident # 29 on 3/18/13 at 9:15 a.m. The documentation related to immunizations for Resident #29 indicated she had received a 1st step tuberculin (TB) test on 9/19/12. There was no documentation of a 2nd step TB test noted. A request was made on 3/18/13 at 1:40 p.m., to the Director of Nursing relating to the 2nd step TB test for Resident #29. The Assistant Director of Nursing indicated at on 3/18/13 at 4 p.m., she had no additional information to provide related to the TB test for the above resident.		the ADON or designee and the results will be brought to the next scheduled QA Committee meeting. This will continue on an ongoing basis.	